Before the
Federal Communications Committee
Washington, D.C. 20554

In the Matter of	)	
Further Modernization of	)	CC Docket No. 02-60
the Rural Health Care Program	)	

Comments of the Utah Telehealth Network in support of
The Petition for Rulemaking filed December 7, 2015 by
Schools, Health & Libraries Broadband Coalition and partners

The Utah Telehealth Network (UTN) was a partner in the Petition for Rulemaking filed December 7, 2015 by the Schools, Health & Libraries Broadband (SHLB) Coalition and six state and regional telehealth networks[1]. UTN appreciates the FCC's invitation to comment on the Petition. We stand strongly behind the full Petition and would like to use this opportunity to reiterate a few points especially important from our Utah perspective.

UTN would not exist today without the Rural Health Care Programs created by the FCC and administered by USAC. Initially a T1 network built with discounts through the RHC Telecommunications Program, UTN benefited from Rural Health Care Pilot Program funding, which allowed us to add HCPs, increase bandwidth and lease MetroE services delivered via fiber and microwave. Calendar year 2016 will be our last year of Pilot Program funding so we have begun our consortia application to migrate to the Healthcare Connect Fund. Based upon 16 years of RHC experience, our comments focus on three areas: challenges for remote rural HCPs and open consortia; the desire for a clear path for joint health care – education networks; and the changing health care delivery system.

I. Challenges to remote rural health care providers (HCPs) and consortia applicants.

Utah is similar to other large western states where the majority of the population and health care resources are concentrated in urban areas. In sparsely populated rural Utah, a local critical access hospital, federally qualified health center or other health care facility may be the only option for health care in a community, frequently functioning as a safety net provider. These HCPs rely on

[1] Petition for Rulemaking by Schools, Health & Libraries Broadband Coalition, California Telehealth Network, New England Telehealth Consortium, Health Information Exchange of Montana, Utah Telehealth Network, Colorado Telehealth Network and Southwest Telehealth Access Grid Seeking Amendment of Part 54 of the Commission's Rules to Further Modernize the Rural Health Care Program, CC Docket No. 02-60 (filed Dec. 7, 2015) http://apps.fcc.gov/ecfs/comment/view?id=60001324308 .

network connectivity for daily operations, telehealth, patient data using remotely hosted electronic medical records, lab and radiology systems, and practice management systems.

However, that connectivity is often expensive. In many rural Utah communities, there is only a single telecommunications provider. These providers deliver quality broadband access, but they do it without the benefit of economies of scale. We have not yet conducted a competitive bid for the HCF program, but our experience during the Pilot Program was that remote rural HCPs can expect monthly prices up to 3.1 - 4.7 times higher than those experienced by urban HCPs for the same bandwidth levels. Given past pricing ratios, we anticipate that post-discount HCF rural rates will, at times, be higher than pre-discount urban rates for the same broadband speeds. The disparity is typically greater for one time last mile and entrance facility fees[2]; 35% of these fees may well be cost-prohibitive for new rural HCPs wanting to join the network.

For San Juan County, including the Utah portion of the Navajo Reservation which experienced the high prices noted above, and where the 2010 population density was 1.9 persons per square mile[3], the Utah Education Network receives a 90% E-rate discount for schools and libraries. Health care facilities in the same communities facing the same challenges will be limited to the 65% discount. While the E-rate discount is based upon overall student household income, the E-rate discount matrix also addresses rural disparities by increasing the majority of the discount bands by 10% for rural locations[4]. If a purpose of the RHC programs is to address health disparities between rural and urban areas, an additional discount for rural HCPs, similar to that provided in the E-rate program, would represent a positive step in that direction.

The Petition outlines public policy benefits of open consortia, especially for small and unaffiliated safety net providers and the adoption of broadband-based care models, but also outlines the challenges facing open consortia. These are very real for us. UTN serves as consortium lead, administers RHC programs, provides 24/7 network and security monitoring and management, videoconferencing services, telehealth and technical support with a staff of 10 and a lean budget. To make network participation affordable for our HCPs, during the Pilot Program UTN has relied on "postalized" rates, which are standardized monthly rates based upon level of bandwidth, regardless of geographic location. UTN's postalized rates include post-discount local network and core infrastructure charges, as well as UTN administrative and network management fees, which have helped cover our costs as consortium lead and network manager. Pooling resources and costs has

[2] See Petition for Rulemaking, footnote 42
[3] US Census State and County Quick Facts, http://quickfacts.census.gov/qfd/states/49/49037.html
[4] E-Rate discount matrix: http://www.usac.org/_res/documents/sl/pdf/samples/Discount-Matrix.pdf

made it more affordable for the remote rural sites to join the network. The key for this method to work is that fees must remain sufficiently attractive for those HCPs, typically urban, that may have other options for connectivity. We are concerned that by more than doubling the HCP portion, postalized rates will be less attractive and possibly not competitive enough with other options available to these urban sites. Fewer participating sites mean higher rates for remaining sites. We are concerned about the impact this will have on network membership moving forward.

UTN reiterates the Petition's recommendation to improve discounts for rural HCPs and consortia.

II. A clear path utilizing RHC and E-Rate to foster health care & education partnerships.

UTN is fortunate to be in a state with a large, robust education network, the Utah Education Network (UEN). In 2014, the Utah Legislature passed H.B. 92 to merge the two organizations, creating the Utah Education and Telehealth Network (UETN)[5]. The Legislature believed that combining UTN and UEN would create efficiencies as we offer many of the same services (network, videoconferencing, USAC consortia applications, etc.) to non-profit and public entities in the same geographic locations. The legislation defined a governance structure and encouraged us to look for synergies in operations and opportunities to merge infrastructure. Our staffs are now co-located and work together in many areas.

We have been exploring how UTN could utilize UEN's state-wide backbone to increase bandwidth to our HCPs. (The last page of this document shows a map of communities served by UTN overlaid with UEN's backbone.) We know how to proceed from a technical perspective and believe it would be cost–effective for all involved: our HCPs, UTN, UEN and USAC. A shared network would be especially beneficial in remote communities where both UEN and UTN have struggled to provide network services, preferably leased, for schools, libraries and health care facilities. However, there is no clear mechanism in the current USAC programs for UTN to utilize UEN's existing network.

We reiterate the Petition's recommendation for the Commission to consider closer alignment between E-Rate and RHC programs and develop clear guidelines for cost allocation of shared networks.

[5] Utah Legislature 2014 General Session, HB92 Utah Education and Telehealth Network, http://le.utah.gov/~2014/bills/static/HB0092.html

III. Recognition of changes to health care delivery

The Petition recommended that the Commission consider discounts for wireless broadband costs associated with remote patient monitoring as requested by CHRISTUS Health. This request illustrates the changing nature of health care delivery: patient care is moving to the patient. Remote patient monitoring, telemedicine visits and patient education via mobile and home devices are rapidly becoming the norm. Patients are being provided with devices and tablets locked down for specific clinical use. Medical peripherals are being developed for use with mobile devices. The patient data captured through these devices may upload directly into the HCPs' electronic medical records. UTN, the University of Utah, and a group of community health centers conducted a three year remote monitoring and patient education pilot for underserved diabetic and hypertensive patients. Clinical outcomes were good but we discovered that accessible wireless broadband was essential to patient compliance and success, especially for rural patients.

We encourage the Commission to formally explore this issue.

Thank you to the Commission for the opportunity to share our concerns here and in the Petition for Rulemaking, and for your work to address health disparities in rural and underserved communities.

Respectfully submitted,

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UETN Infrastructure Map

Connecting 1447 locations throughout Utah